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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

RICHARD GILMORE, M.D. and PRATAP SARAF, M.D.,
Petitioners,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services

and

S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Respondents.

Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, in light of conflicting directions emanating from two lines of decision by this Court, courts must defer to retroactive legislation purporting to clarify the intent of an earlier Congress, even though the circumstances of the later enactment indicate that Congress was not interpreting prior law, the affected statutes were enacted eleven years earlier, and the appellate courts, prior to the later enactment, had unanimously interpreted the affected statutes to the contrary.

2. Whether Congress, consistent with Article III of the Constitution, may apply a new statute to direct the outcome of litigation to which the United States is a party in order to benefit the federal government, where the statute has no other retroactive effect.

3. Whether the retroactive application of a new statute, resulting in a reduction of the statutory rate of payment to health care providers for services already provided to certain federal beneficiaries, impairs vested property rights protected by the Due Process Clause and the Takings Clause of the Fifth Amendment and, when applied by the States, the Contract Clause of Article I.

4. Whether, prior to passage of the Balanced Budget Act of 1997, federal law permitted the States to limit "Medicare cost sharing" payments on behalf of "Qualified Medicare Beneficiaries"?

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OPINIONS BELOW

The opinion of the court of appeals is reported at *Beverly Community Hosp. Ass'n v. Belshe,* 132 F.3d 1259 (CA9 1997) and is reprinted in the Appendix hereto. The opinion of the district court granting summary judgment in favor of the petitioner is not reported and is also reprinted in the Appendix.

JURISDICTION

The judgment of the court of appeals was entered on December 2, 1997. A timely Motion for Rehearing With Suggestion for Rehearing *En Banc* was denied on March

3, 1998, and this Petition for Certiorari was timely filed. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

This case concerns the interpretation of 42 U.S.C. §§ 1396a(a), 1396a(n), and 1396d(p), and the related provisions of 42 U.S.C. §§ 1395*l*(a)(1), 1395u(h)(1), 1395w-4, 1396b(b), and 1396c, all of which are set forth in the Appendix. This case also concerns issues arising under Article I, § 10, Article III, § 1, and Amendment V of the United States Constitution, which provisions are set forth in the Appendix.

STATEMENT OF THE CASE

Petitioners are medical doctors who practice in California. They provide medical services to low-income persons, including some who are entitled to coverage under Part B of the federal Medicare program.

The Petitioners (the "Physicians") filed this action in 1996 in the United States District Court for the Central District of California against Respondents, the director of California's Department of Health Services and the federal Secretary of Health and Human Services (the "Secretary"). The Physicians alleged that the California Medicaid program ("Medi-Cal"), with encouragement from the United States, had illegally refused to pay them the 20 percent coinsurance and other "cost-sharing" that federal law required that the states pay on behalf of low-income patients enrolled in Medicare Part B and known as "qualified Medicare beneficiaries" ("QMBs"). The district court entered judgment for the Physicians in December, 1996, and issued an appropriate injunction.[1]

While an appeal was pending in the Ninth Circuit, Congress passed the Balanced Budget Act of 1997 ("BBA")

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[1] Petitioners filed this case as a class action, but no class was certified after Respondents agreed that they would honor the result for all persons providing services to QMBs in California.

which contained a provision (§ 4714) purporting to "clarify" the Medicaid Act to eliminate prospectively any right of medical providers to payment of the 20 percent cost-sharing for QMBs. Section 4714 also applied retroactively to any pending litigation.

The Ninth Circuit reversed, relying on the BBA, though it noted that all four federal appellate courts to rule on the issue before passage of the BBA had found prior law to require the contrary result.

A. QMBs and Medicare Cost-Sharing

This case involves the construction of federal statutes which, Physicians contend, required the states to pay Medicare copayments, known as "cost-sharing," on behalf of Qualified Medicare Beneficiaries, the QMBs, before the 1997 amendment. The case also involves construction of the 1997 "clarifying" enactment and evaluation of whether its retroactive aspect is unconstitutional.

Some background is necessary on QMBs and the law governing payment for their care. All QMBs are eligible for coverage under both parts of Medicare, the federal health insurance program for the elderly and disabled. Part A of Medicare automatically covers hospital and other institutional care for most Social Security beneficiaries. *See* 42 U.S.C. §§ 426(a), 1395c to 1395i-4. Medicare Part B, a supplemental program, requires that an eligible person enroll and pay a premium (much like a commercial insurance plan). *See id.* §§ 1395o-1395s. Part B covers services of physicians and other health professionals, as well as those of ambulance, home care, and medical equipment suppliers. *Id.* §§ 1395j-1395w-4j.

Medicare Part B pays 80 percent of the "reasonable charge" for most covered services. The beneficiary is responsible, in the ordinary case, for paying 20 percent of the charge—the "cost sharing" or coinsurance. *Id.* § 1395*l* (App. 25a); 42 C.F.R. §§ 424.55, 400.202 (App. 32a);

See also Your Medicare Handbook 1997 at 18-21 (App. 43a-49a). The "reasonable charge" for physician services is based on an annual fee schedule set by the Secretary. 42 U.S.C. § 1395w-4 (App. 26a).

Medicaid, the other relevant program, pays for medical assistance for the poor of any age. The federal and participating state governments (all 50, during the relevant time) jointly fund and administer Medicaid. *See id.* §§ 1396b, 1396d(b) (App. 28a, 29a).

Each participating state enters into an agreement with the Secretary and must implement a "State Plan" which meets federal requirements as to, among other things, the individuals and services to be covered and the amount that physicians and other providers will be paid for services. *Id.* §§ 1396a, 1396b (App. 27a, 28a); *Harris v. McRae*, 448 U.S. 297, 301 (1980). Most states adopt a fee schedule or otherwise set rates for the amounts to be paid physicians and other providers. *See* 42 U.S.C. § 1396a(a)(30). The federal government oversees the states' administration of the program and compliance with federal law, *id.* § 1396c, and reimburses each state for at least one-half of the costs it incurs. *See id.* §§ 1396b, 1396d(b) (App. 28a, 29a).

The first statute at issue requires that an approved state Medicaid plan cover the Medicare "cost sharing" of QMBs, their coinsurance and other copayment items. *See* id. § 1396a(a)(10)(E) (App. 27a). The QMB population includes two categories of low-income elderly and disabled: (1) a group of Medicare beneficiaries who are poor enough to qualify for full Medicaid benefits ("dual eligibles"), and (2) a second group, also Medicare beneficiaries, whose income is too high for Medicaid but otherwise falls below a statutory low-income standard ("pure QMBs"). *See id.* § 1396d(p)(1); *Pennsylvania Medical Soc'y v. Snider*, 29 F.3d 886, 889 (CA3 1994). The

second population, the so-called pure QMBs, is not eligible for Medicaid, though Medicaid is designated by statute to cover Medicare cost-sharing. *See* 42 U.S.C. § 1396a(10)(E)(VIII); App. 27a. Enacted in 1986, the statute has made state coverage of cost-sharing for both categories of QMBs mandatory since an amendment in 1988. *See* Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 683, 748 (1988).

The second key statute sets out the elements of Medicare "cost-sharing" of QMBs to be covered under a state Medicaid plan, including, as relevant here: (i) Medicare Part B premiums; (ii) annual deductibles for Part B; and (iii) coinsurance under Part B. 42 U.S.C. § 1396d(p)(3); App. 30a-31a. States are required to cover these costs regardless of whether the same services would be covered under the state's Medicaid plan. *Id.*, § 1396d(p).[2] The meaning of this statute is undisputed.

Congress enacted a third statute in 1986, 42 U.S.C. § 1396a(n). Prior to its amendment in 1997 as part of the BBA, Section 1396a(n) stated that a state "may" exceed its Medicaid rates in paying Medicare cost-sharing amounts on behalf of QMBs. *See id.* (West 1997 Supp.); App. 27a. The dispute here arose from the Secretary's attempt to use § 1396a(n) to limit §§ 1396a(a)(10)(E) and 1396d(p)(3).

After enactment of the three statutes, the Secretary permitted states to limit—and, in almost all cases, to fail to

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[2] The statutory specification of the obligation to cover Part B coinsurance is stated in terms of a specific formula. The costs to be covered are defined as "[t]he difference between the amount that is paid under section 1395*l*(a) of this title and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'." 42 U.S.C. § 1396d(p)(3)(D). Section 1395*l*(a) of the Medicare Act states, with respect to physician services covered by Part B, that Medicare will pay 80 percent of the Medicare-approved fee schedule amount.

pay—Medicare cost-sharing payments for QMBs. The federal government eventually took the position that states were not required to pay the 20 percent Part B coinsurance on behalf of QMBs to the extent that the amount paid by Medicare (i.e., 80 percent of the Medicare rate) exceeded the amount that the state Medicaid program would pay for the same service. California adopted the policy by statute. *See* Calif. Welfare and Instit. Code § 14109.5.

The policy allowed California, and many other states, to avoid virtually all payment of Medicare cost-sharing for services to QMBs. In almost all cases, California's Medicaid payment rates are lower than the 80 percent federal share of a Medicare Part B payment. Under the policy, physicians and suppliers in California usually received nothing for part B coinsurance on behalf of QMBs and were paid only 80 percent of the Medicare rate for services provided to these Medicare beneficiaries.

The Secretary concurred in and approved California's non-payment of the QMBs' coinsurance.

B. Prior Litigation

Physicians and suppliers in other states that had adopted the same limitation on payment of QMB cost-sharing sued the Secretary and applicable state officials and prevailed in all four cases to reach the courts of appeals. In each instance, the court of appeals held that 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p)(3) clearly required states to pay the full 20 percent Medicare coinsurance on behalf of QMBs and that the Secretary lacked authority to permit the states to cap those payments at a Medicaid fee schedule amount. *See New York City Health and Hosps. Corp. v. Perales,* 954 F.2d 854, 858-63 (CA2 1992); *Pennsylvania Medical Soc'y v. Snider,* 29 F.3d 886, 892-97 (CA3 1994); *Haynes Ambulance Service v. Alabama,* 36 F.3d 1074, 1076-77 (CA11 1994)

Rehabilitation Ass'n of Virginia v. Kozlowski, 42 F.3d 1444, 1450-60 (CA4 1994) ("the four Circuits").

The Secretary argued in those cases that 42 U.S.C. § 1396a(n), by implication, authorized the states to pay less than the Medicare rates for services to QMBs. In particular, the Secretary contended that because the statute provided that the States "may" pay more than their standard Medicaid rates on behalf of QMBs, they also "may" choose not to pay more than those rates. The Secretary asserted that this regulatory interpretation was entitled to deference under *Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). *See e.g., Kozlowski*, 42 F.2d at 1450; *Snider*, 29 F.3d at 902-03; *Perales*, 954 F.2d at 858, 861-62.

The four Circuits each concluded, however, that the intent of §§ 1396a(a)(10)(E) and 1396d(p)(3) was clear and contradicted the Secretary's interpretation, and that *Chevron* deference was inappropriate. *See Perales*, 954 F.2d at 858-62; *Snider*, 29 F.3d at 892-97, 902-03; *Kozlowski*, 42 F.3d at 1450-60; *Haynes*, 36 F.3d at 1076-77 (adopting and expanding upon the *Snider* analysis).

Three of the four Circuits concluded that 42 U.S.C. § 1396a(n) was better understood as an exception to the Medicaid Act's requirements in 42 U.S.C. §§ 1396b(a)(1) and 1396a that states not exceed payment schedules or methods otherwise approved in a State Plan. *See Haynes*, 36 F.3d at 1076-77 (incorporating *Snider*'s reasoning); *Snider*, 29 F.3d at 894-96; *Perales*, 954 F.2d at 859-60. This view recognized that when states pay the Part B coinsurance on behalf of QMBs, providers receive 100 percent of the Medicare-approved rate—which in most cases is more than the Medicaid rate for the same service. But for § 1396a(n), such payments would violate the Medicaid State Plan requirements. *See id.*

C. Trial Court Proceedings

The district court granted summary judgment for the Physicians and entered a declaratory judgment that California's QMB payment limitation, approved by the Secretary, violated the Medicare and Medicaid Acts, "including but not limited to 42 U.S.C. § 1396a(a)(10)(E)." App. 28a. The court also held that the policy violated plaintiffs' rights under 42 U.S.C. § 1983 to the extent that it denied full payment of Medicare cost-sharing on behalf of QMBs. App. 21a. The court enjoined the Respondents from approving, allowing to be implemented, and enforcing the challenged policy to the extent that it violates federal law by preventing plaintiffs from receiving full compensation for services provided to QMBs. *Id.*

The Respondents appealed the district court's judgment to the United States Court of Appeals for the Ninth Circuit.

D. The Balanced Budget Act of 1997

While the appeal was pending, the President signed the Balanced Budget Act of 1997 ("BBA"), Pub. L. 105-33, 111 Stat. 251, in August of last year. Section 4714(a) of the BBA amended 42 U.S.C. § 1396a(n) by adding new provisions which expressly authorize the states to limit Medicare cost-sharing payments for QMBs based on Medicaid rate schedules and, further, prohibiting physicians and suppliers from billing individual QMBs to the extent that a state does not pay the full Medicare cost-sharing amount. *See* App. 33a-35a. Section 4714(a) also added a "savings" provision to Section 1396a(n) preserving the rights of physicians and suppliers to collect cost-sharing amounts in such cases from commercial insurers in the event an individual QMB might be able to afford a private Medicare supplemental insurance policy. App. 34a.

The caption to Section 4714(a) ("Clarification Regarding State Liability for Medicare Cost-Sharing") and the accompanying Conference Report indicate that Congress purported to enact a "clarification" of Section 1396a(n)'s prior language that the four Circuits had interpreted to the contrary. *See* H. Conf. Rep. 105-217, 105th Cong., 1st Sess. (July 30, 1997) at 870-71; App. 35a, 38a.

The BBA made the amendments in Section 4714 effective prospectively, to QMB cost-sharing payments made on and after the date of enactment (August 5, 1997), and retrospectively, to a state's payment for "items and services furnished before" enactment "if such payment is the subject of a law suit that is based on" 42 U.S.C. §§ 1396a(n) and 1396d(p) and "is pending as of, or is initiated after, the date of enactment of this Act." App. 35a (BBA, § 4714(c)). The BBA thereby made Section 4714 applicable to payment for services already provided if payment for those services had been or would be sought through the courts.

E. The Court of Appeals' Decision

The Ninth Circuit reversed, accepting jurisdiction under 28 U.S.C. § 1291. App. 5a. The court of appeals held that the "clarification" in Section 4714 of the BBA must be given "great weight" under *Loving v. United States,* 517 U.S. 748, 116 S.Ct. 1737, 1749 (1996), and *Red Lion Broadcasting Co. v. FCC,* 395 U.S. 367, 381-82 and n.8 (1969) and by itself defeated Petitioners' claims. App. 12a-15a; 132 F.3d at 1265-67.

The court acknowledged that the four Circuits had "uniformly rejected [the] Secretary's reading" of the applicable statutes. *See* App. 14a; 132 F.3d at 1266. The court of appeals found a "split of authority" in what it described as the differing explanations of the former language of Section 1396a(n) by the four Circuits and several district courts, however, and concluded that the

changes the BBA made in the statute simply clarified it. App. 7a-8a, 14a-15a; 132 F.3d at 1263 n.4, 1266. The court described the Medicare and Medicaid acts as "baffling," and the 1997 amendments as "worthy of real deference" given that courts had had "extraordinary difficulty" in "divining the intent of the original Congress" that enacted Section 1396a(n). App. 14a-15a; 132 F.3d at 1266. The Ninth Circuit concluded it should "honor Congress' 'clarification' label and accept . . . § 4714's provisions as a statement of what Section 1396a(n) has meant all along." App. 15a; 132 F.3d at 1266.

The court of appeals did not analyze the meaning of the applicable statutes as they existed before the BBA, other than to add that it had "carefully explored the litigants' arguments" on that topic and on the constitutional issues the Physicians had raised. App. 15a-16a; 132 F.3d at 1266-67. The court held that its finding that Section 4714 was a clarification of prior law mooted the Physicians' claims of violations of substantive due process, the Contract Clause and the separation of powers. The court of appeals held that the constitutional arguments rested entirely on the premise that Section 4714 of the BBA was retroactive, rather than a "declaratory clarification of" of prior law. *Id.*

The court of appeals also found no Article III objection to the retroactive application of the 1997 amendments on the ground that Petitioners' case was "pending" on appeal at the time of enactment and the BBA amendments reflected a congressional intent to resolve all pending disputes. App. 10a-12a; *id.* at 1264-65. Applying its decision in *Gray v. First Winthrop Corp.*, 989 F.2d 1564 (CA9 1993), the Ninth Circuit stated that "[b]ecause Congress thus has such authority to *change* the law as to pending cases, its power to *clarify* the law—to confirm what the law has always meant—follows a fortiori." App. 12a; *id.* at 1265 (emphasis in original).

SUMMARY

The tension between decisions of four courts of appeal and a contrary congressional "clarification" with retrospective application which deprives citizens of vested property rights in order to gain budgetary savings focuses the significance of this case. In light of confusion among this Court's prior decisions on the weight to be given to Congress' reinterpretation of existing statutes and on relevant Separation of Powers doctrine, the issues here provide several bases for a grant of certiorari.

Four courts of appeals determined that federal statutes prior to August, 1997 required that physicians and other suppliers be paid full Medicare rates for services to QMBs. Congress amended the law in 1997, purporting to clarify it and retroactively to eliminate the right to full Medicare payment for past services as to which a lawsuit had been filed. Two later appellate decisions, including the court of appeals below, followed the congressional interpretation.

Certiorari should be granted to clarify this Court's prior instructions on the extent to which courts should defer to a later Congress' interpretation of an earlier statute (here, the provisions for payment in the QMB statutes). One line of cases, which includes *Loving v. United States*, 116 S.Ct. at 1749, states that subsequent legislation declaring the intent of an earlier statute is entitled to "great weight" in statutory construction. Another line of cases, represented by *United States v. Philadelphia National Bank*, 374 U.S. 321, 348-49 (1963), instructs that, "The views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." The appellate courts are "in a quandary" over the conflict and "would welcome clarification by the Supreme Court." *See Paramount Health Systems, Inc. v. Wright*, 138 F.3d 706, 711 (CA7 1998).

Equally important, the Court should also grant certiorari to untangle the meaning of *United States v. Klein*,

13 Wall (80 U.S.) 128 (1872), and its impact on the selective retroactivity of an enactment such as the 1997 "clarification" in the Balanced Budget Act here. Whether *Klein* requires that retroactive legislation, which affects only pending lawsuits and effectively directs the outcome in favor of the federal government as a party to them, must be invalidated as a usurpation of the Article III role of the judiciary in interpreting a statute is a recurring and unresolved issue. The purported clarification also raises serious constitutional questions about Congress' (and the states') ability to impair vested contract rights having extinguished a statutory right to payment for services already rendered.

Further, this Court should resolve the conflict that now exists in the courts of appeal concerning the proper interpretation of the original, pre-1997 QMB payment statute —a conflict that exists solely as a consequence of the congressional enactment, eleven years later, of the new statute purporting to "clarify" the intent of the original enacting Congress.

The actions of Congress at issue undermine the integrity of federal health care and procurement programs. The Physicians acknowledge that Congress may change the law, and in so doing change the prospective expectations of those who contract with the federal government. The court of appeals in this case, however, has ceded to Congress the authority to reinterpret the rules that applied to transactions entered into years ago in order to change the terms of contracts for services already performed.

This degree of deference inappropriately elevates one line of the Court's decisions over another, the *Philadelphia National Bank* line, and permits the United States to trample concepts of the constitutional balance of powers, substantive due process, non-impairment of contracts, and just compensation in the interest of budgetary convenience.

The net effect of Congress' action makes the government a particularly "[un]reliable contracting partner," contrary to this Court's admonition in *United States v. Winstar Corp.*, 518 U.S. 839, 116 S.Ct. 2432, 2459 (1996), that the United States lacks power to repudiate its own debts simply to save money. *See id.*, 116 S.Ct. at 2459-60 & n.28, 2464-65 & n.39, 2468-69 n.51 (plurality opinion) *id.* at 2473, 2475-76 (Breyer, J., concurring); *id.* at 2478-79 (Scalia, J., concurring).

REASONS FOR GRANTING THE PETITION

I. THE DECISION BELOW AND A RECENT DECISION OF THE SEVENTH CIRCUIT COURT OF APPEALS HIGHLIGHT THE NEED TO RESOLVE THE CONFLICTING STANDARDS FOR JUDICIAL DEFERENCE TO STATUTORY INTERPRETATIONS BY THE LEGISLATIVE BRANCH.

A. The Purported "Clarification" of 42 U.S.C. § 1396a(n) in the Balanced Budget Act of 1997 Unconstitutionally Displaced the Circuit Courts' Unanimous Interpretation of Prior Law and Created Conflict in the Circuits.

Section 4714 of the Balanced Budget Act of 1997 purports, retroactively, to "clarify" a law that four circuit courts of appeals had found to have a clear meaning to the contrary. The Second, Third, Fourth, and Eleventh Circuits had unanimously rejected the Secretary's interpretation of the pre-1997 law and held that the plaintiffs, all situated identically to the Physicians, were entitled to full payment for services rendered to QMBs at the statutorily-defined Medicare rates. Through Section 4714, Congress plainly acted to deprive the Physicians and similarly-situated litigants of an objective judicial interpretation of their statutory rights. The statutes at issue are complex, but as the Second Circuit recognized:

> [C]omplexity is not the same as ambiguity. Congress passes legislation with specific purposes in mind.

> When the ordinary tools of statutory construction permit us to do so, we must attempt to discover those purposes from the text, structure, history of the acts in question.

Perales, 954 F.2d at 862-63.

The four Circuits ascertained the purposes of the original 1986 statute from its text, structure, and history. All four courts found a plain meaning interpretation of the statute sufficient to make inapplicable any deference to the Secretary's contrary interpretation. *See Snider*, 29 F.3d at 902 ("Our analysis reflects that although interpreting the relevant statutory provisions is not a simple task, there is in fact no ambiguity as to how much states have to pay. . . . Accordingly, *Chevron* has no application"); *Perales*, 954 F.2d at 862-3 ("[W]here we confront a statute that evinces a legislative purpose clearly at odds with the proffered administrative interpretation, we should not defer"); *Kozlowski*, 42 F.3d at 1459 ("[T]here can be no doubt but that the QMB is a Medicare enrollee, and that payment on her behalf must be made at the Medicare rate"); *Haynes*, 36 F.3d at 1076 ("the statute unambiguously requires the state to pay the full amounts specified. . . .").

The Ninth Circuit below and, more reluctantly, the Seventh Circuit a few months later, concluded, however, that the four Circuits' statutory analysis must give way to the intervening clarification of Congress. The two courts principally relied on a line of this Court's decisions represented by *Loving v. United States* for the proposition that the enactment of a subsequent Congress is to be given "great weight" in interpreting prior law. *See Beverly Comm. Hosp.*, 132 F.2d at 1265-66 (App. 12a-13a); *Paramount*, 138 F.2d at 710-11. The court of appeals deferred to Section 4714 without even analyzing the prior law. App. 10a, 14a-16a; 132 F.3d at 1264, 1266-67.

But the *Loving* line of analysis conflicts, in these circumstances, with the line of cases defined by *Philadelphia National Bank*, holding that "[t]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *See* 374 U.S. at 348-49. Moreover, as the Seventh Circuit strongly suggested, the *Philadelphia National Bank* line is more in concert with the facts of this case. *See Paramount*, 138 F.3d at 710 ("Nothing in the [BBA] provisions themselves suggests a process of interpretation. . . .").

B. The Objective Circumstances of the Enactment of § 4714 Are at Odds With the Deference Given to That Statute by the Court of Appeals.

The language and architecture of Section 4714 indicate that it is a wholesale change in the law intended to create the authority that the four Circuits had found lacking in the prior statutes. Enacted purely as a budgetary measure, Section 4714 is not a mere interpretation or clarification of prior law.

Unlike the Ninth Circuit below, the Seventh Circuit recognized the logical difficulty with accepting Section 4714 as a "clarification" of prior law. As Judge Posner observed, Congress was not actually "interpreting" prior law when it passed its "clarification," but rather was overturning judicial interpretation of the law to create budgetary savings. Instead of a "clarification," [i]t is far more realistic to regard the 1997 [QMB] provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government." *See Paramount*, 138 F.3d at 710.

> The location of the 1997 ["clarifying"] amendments in a statute labeled the "Balanced Budget Act" and concerned previously with cutting the federal deficit hardly creates confidence that Congress was, court-like, interpreting the 1986 statute. Nothing in the provisions themselves suggests a process of interpre-

> tation; they merely declare that the states are not required to reimburse [QMB] providers at the Medicare rate.

Id.

Section 4714 did not modify or elucidate the language of the original § 1396a(n) to provide the "cap" the Secretary argued was always contained within it. To the contrary, Section 4714 added a completely new provision to achieve that result. The new provision, designated 42 U.S.C. § 1396a(n)(2), provides that the states may now limit their co-payments for QMBs by capping physician payments at the lower state Medicaid fee schedules. App. 35a. Congress kept the original provision intact, renumbered as 1396a(n)(1). *Id.*

The original provision may not be rendered mere surplusage by Section 4714, according to the cardinal rule that all parts of a statute be given effect. *See Morton v. Mancari*, 417 U.S. 535, 551 (1974). The old Section 1396a(n) must therefore serve the purpose it always served, i.e., to make clear that the states would not violate their own Medicaid plans when making QMB payments at the higher Medicare rate, as explained in *Snider*. *See* 29 F.3d at 895.

Section 4714 contains two additional provisions which confirm that Congress substantively changed the law. First, in authorizing the states to pay less than the full Medicare cost sharing amounts, Section 4714 added—for the first time—provisions (designated as §§ 1396a(n)(3)(A) and (B)) which specifically state that the total of whatever payment is now made by the state (even if zero), plus the payment from Medicare (i.e., 80 percent of the Medicare rate), "shall be considered to be payment-in-full for the service" and that "the beneficiary [i.e., the QMB] shall not have any legal liability to a provider" for any unpaid amounts. These new provisions could only have been necessary to insulate QMBs against financial exposure otherwise created by the principal changes in the law (i.e., § 1396a(n)(2)), which, by authorizing the states

to pay less than the full Medicare cost-sharing amount, would have encouraged Physicians to seek cost-sharing from the QMBs themselves. Under the original (pre-Section 4714) statute, QMBs remained liable for any unpaid portion of their bills for items and services provided to them under the Medicare program, up to the full Medicare rate.

Viewed logically, the enacting Congress chose not to hold the QMBs harmless in this circumstance because it envisioned that the states would fulfill their obligations to pay the cost sharing in full, leaving no real financial exposure for the QMBs. In other words, the original statute did not specifically address this problem because Congress did not believe it had created the problem.

The new subsection 1396a(n)(3) also provides that its terms are not intended to prevent full payment for QMBs at the higher Medicare rate if the co-payments can be obtained from some other third-party source such as "a Medicare supplemental policy or an employer retiree health plan." App. 34a. This provision, likewise, was necessary only because Section 4714 gave the states a *new* option to "cap" their Medicare cost-sharing payments at the lower Medicaid schedule amounts.[3]

Standing alone, nothing in the language or construction of the amendments made by Section 4714 indicates that its purpose is anything other than a change in the law. Rather, the purported purpose of "interpreting" the statute originally enacted in 1986 is discernable only from the caption attached to the uncodified statute and the accompanying legislative history. The court of appeals in fact heavily relied on the title of Section 4714(a), despite its recognition that titles are not properly considered in statutory construction except where ambiguity exists (and none

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[3] In addition, the new law was given both an "effective" date and a purported "retroactive" application. App. 35a. A true "clarification" would require neither because it would merely elucidate the already present meaning of the original statute.

even arguably exists in the BBA amendments). *See* App. 13a-14a; 132 F.3d 1265-66 and n.6. Any contemplated reliance on those sources would fall squarely within the concerns expressed in *Philadelphia National Bank* against conclusive reliance on legislative history—particularly the discovered interpretations of a later Congress.

C. This Court's Guidance Is Required to Clarify the Bounds of Judicial Deference in These Circumstances.

All circuits that interpreted the relevant statute *before* the congressional "clarification" held against the interpretation urged by California and the Secretary. It was only *after* Section 4714 that the Ninth Circuit and the Seventh Circuit held to the contrary, in reliance on the *Loving* line of cases.

The Seventh Circuit followed *Loving* most reluctantly, noting that

> [W]e're in a quandary concerning the vitality of the *Loving* line, and would welcome clarification from the Supreme Court—pending which we feel constrained by *Loving* to give *some* weight to Congress' declaration in the Balanced Budget Act. . . . It is enough to tip the balance in favor of [the government's proffered interpretation] . . . and *while it seems to us that Paramount has the better interpretation,* there is sufficient ambiguity to require us to defer to the government.

Paramount, 138 F.3d at 711 (first emphasis in original; second emphasis added).

The Ninth Circuit gave no serious consideration to the *Philadelphia National Bank* line of cases. The court of appeals disposed of those decisions by limiting their concerns to unwarranted reliance on subsequent legislative history (as opposed to subsequent legislation) to interpret the meaning of a prior law. *See* App. 13a-14a; 132 F.3d at 1265-66. But the line between *Philadelphia National Bank* and *Loving* cannot be drawn so simply in this case, if in any.

First, as discussed in Section B., above, Congress' intent to "clarify" rather than change the law is, in fact, primarily evidenced in the title and legislative history of BBA Section 4714. App. 33a, 36a. Moreover, as discussed in Parts II and III, *infra*, the stated intent to "clarify" § 1396a(n) is encumbered by serious constitutional problems which should make the courts reluctant to grant uncritical deference to the clarification label. Perhaps most importantly, however, this Court has not viewed the line between reliance on subsequent legislation and reliance on subsequent legislative history to be as immutable as the Ninth Circuit believed.

This Court has stated, "We have observed on more than one occasion that the interpretation given by one Congress (or a committee or a Member thereof) to an earlier statute is of little assistance in discerning the meaning of that statute." *Public Employees Ret. System v. Betts*, 492 U.S. 158, 168 (1989). A later statute may, depending on the circumstances, have "little, *if any*, significance" in interpretation of the earlier enactment. *See Rainwater v. United States*, 356 U.S. 590, 593 (1958) (disregarding later statute) (emphasis added); *see also South Dakota v. Yankton Sioux Tribe*, 118 S. Ct. 789, 803 (1998) (same); *Gwaltney of Smithfield, Ltd. v. Chesapeake Bay Fdn., Inc.*, 484 U.S. 49, 63 n.4 (1987) (same); *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 839-40 (1988) (same).

In contrast to the Ninth Circuit in this case, the Seventh Circuit in *Paramount* suggested that the reasoning of *Philadelphia National Bank* may be more appropriate in circumstances like those here, where Congress' subsequent declaration of its predecessors' intent serves a wholly distinct budgetary purpose. *See* 138 F.3d at 709-10. Congress plainly sought to enhance the expected savings in future years by labeling the change in law a "clarification" and directing the result in cases interpreting the prior law. *Id.; see* App. 33a, 36a. Victory in pending cases would necessarily avoid payment of Medicaid matching funds

from the federal purse. *Cf.* App. 38a-42a (CBO report predicting savings in federal outlays over the next five years).

Even apart from Congress' pecuniary interest in directing the outcome in pending cases, the Seventh Circuit was troubled by the congressional intrusion. As that court noted, there is an "air of unreality" in suggesting that a subsequent Congress can clarify the intent of the body that met eleven years earlier, since "the membership of Congress had largely turned over during the interim and gress is not an interpretive body and has no felt duty to had been members of Congress back in 1986 and remembered what the membership's intentions had been regarding the esoteric issue of the reimbursement rate for providers of medical services to [QMBs]." *Paramount*, 138 F.3d at 709-10.

More fundamentally, Congress by nature is not well suited to interpret the meaning of earlier statutes. "Congress is not an interpretive body and has felt no duty to maintain continuity with the past." *Id.* at 710. That indeed is why "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *See Philadelphia Nat'l. Bank*, 374 U.S. at 348-49.

Yet both the Ninth Circuit below and the Seventh Circuit concluded that the *Loving* line of cases seems to offer no exception to the rule of deference even when a statute is used to heal a litigant's losses. Consequently, disappointed parties—here, the federal government and the states—are encouraged to "scurry to Congress" to try to repeal adverse judicial decisions through more favorable legislative interpretation. *See Paramount*, 138 F.3d at 710.

Certiorari should be granted to clarify the implications of the *Loving* and *Philadelphia National Bank* lines and resolve the "quandary" identified by the Seventh Circuit. *See S.E.C. v. United Benefit Life*, 387 U.S. 202, 207 (1967) (Supreme Court may grant certiorari to resolve

inconsistencies in its own decisions); *Paramount*, 138 F.3d at 711.

II. THE COURT OF APPEALS IMPROPERLY ELEVATED DEFERENCE TO CONGRESSIONAL "CLARIFICATION" ABOVE THIS COURT'S LONG-STANDING INTERPRETATIONS OF THE CONSTITUTIONAL SEPARATION OF POWERS DOCTRINE.

The court of appeals disposed of all separation-of-powers questions by determining, first, that the case was "pending" within the meaning of the effective date clause of Section 4714 and then holding:

> Because Congress thus has such authority to *change* the law as to pending cases, its power to *clarify* the law—to confirm what the law has always meant—follows a fortiori.

App. 12a; 132 F.3d at 1265.

This analysis reflects the traditional rule that courts are to apply the law in effect at the time of decision, *see United States v. Schooner Peggy*, 1 Cranch (5 U.S.) 103, 110 (1801), but begs the more serious and fundamental question as to whether Congress' act was, in the first instance, an impermissible intrusion into the judicial function. In *United States v. Klein*, 13 Wall. (80 U.S.) 128 (1872), this Court made clear that Congress may not prescribe a new rule of decision in pending cases to benefit the United States.

Klein concerned a legislative effort by Congress to "clarify" (i.e., re-define) the rules of decision for certain claims against the United States. The Court held, in the form of questions, that, if it were to heed the congressional instruction, it would be "allowing one party to the controversy to decide it in its own favor" and that to do so would be to permit the legislature to "prescribe rules of decision to the Judicial Department . . . in cases pending before it." *Id.* at 146. This constitutional aversion

was then repeated: "Can it [Congress] prescribe a rule in conformity with which the court must deny to itself the jurisdiction thus conferred [over appeals from the Court of Claims], because and only because its decision, in accordance with settled law, must be adverse to the government and favorable to the suitor? This question seems to answer itself." *Id.* at 147.

As this Court has since noted, "of obvious importance to the *Klein* holding was the fact that Congress was attempting to decide the controversy at issue in the Government's own favor." *United States v. Sioux Nation*, 448 U.S. 371, 405 (1980). "[E]ven more important, the proviso at issue in *Klein* had attempted 'to prescribe a rule for the decision of a cause in a particular way.'" *Id.* (quoting *Klein*, 13 Wall. at 146).

The meaning of *Klein* has been debated by courts and the decision has been described as forbidding Congress to prescribe rules of decision for pending cases without amending the law. Even one decision of this Court, in dicta, so confined *Klein*, stating that the 1992 decision in *Robertson v. Seattle Audubon Society*, 502 U.S. 429, 441 (1992) had modified *Klein* despite that decision's express refusal to do so. *See Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 218 (1995) (quoting *Robertson*, 503 U.S. at 441, in part for the proposition that the prohibition of *Klein* "does not take hold when Congress 'amends applicable law'"); *but see Robertson*, 503 U.S. at 441 (stating that the Court "need not consider whether this reading of *Klein* is correct" because it disagreed with lower court as to whether the statute at issue had amended applicable law).

Even if *Klein* is to be read merely as *Plaut* described it, Section 4714 is constitutionally flawed. Its retroactive aspect affects only a discrete and readily-identifiable category of cases—those in which health care providers have asserted their rights to payment under the prior law. It sweeps no more broadly. It affects no other payments

made, or to be made, for services provided before the effective date. Article III of the Constitution denies Congress the power to enact such a narrowly retroactive statute. *See* App. 24a; *Plaut*, 514 U.S. at 228; *Klein*, 13 Wall. (80 U.S.) at 146-47. The Ninth Circuit's declination to examine this flaw is doubly inappropriate because the prescribed rule of decision eliminates the United States' obligation to fulfill a bargain previously struck to pay for services already performed. *See United States v. Carlton*, 512 U.S. 26, 39-40 (1994) (Scalia, J., concurring) (legislation "eliminating the specifically promised reward for costly action *after* the action has been taken, and refusing to reimburse the cost" is "harsh and oppressive" beyond bounds of Court's substantive due process test) (emphasis in original).

Whatever the exact scope of *Klein*, it must at least mean that Congress violates the separation of powers when that body alters the outcome of pending cases to benefit the federal government. *Sioux Nation* recognized this point, *see* 448 U.S. at 405, and the language of *Klein* has not been disturbed. This case, and others on appeal when the BBA was enacted, involve the federal government as a financially interested party. Section 4714 violated the core holding of *Klein* by intervening to save the government the money it would have lost had the Physicians and other plaintiffs prevailed.

Medicaid is a joint federal-state venture.[4] Application of Section 4714 to pending cases saves money for both the state and federal governments. *See* App. 41a (Con-

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[4] *See Michigan Hosp. Ass'n v. Dept. of Social Services*, 738 F. Supp. 1080, 1081 (W.D. Mich. 1990) (describing Medicaid as "a federal-state joint venture"); *see also Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1998) (Medicaid is a "cooperative" federal-state program); *Harris*, 448 U.S. at 308 (same); *Bowen v. Massachusetts*, 487 U.S. 879, 883 (1987) (same); *Illinois Health Care Ass'n v. Shalala*, 776 F. Supp. 411, 413 (N.D. Ill. 1991), *aff'd*, 983 F.2d 1460 (CA7 1993) (Medicaid is a "joint" federal-state enterprise).

gressional Budget Office estimates of net *federal* savings from Section 4714 totaling $2.1 billion by 2002 and $5.6 billion by 2007). The federal government contributes at least 50 percent of the money used for the cost-sharing payments sought by plaintiffs in this and similar cases, *see* 42 U.S.C. § 1396d(b), and cannot credibly deny the necessary financial effect on it from the application of Section 4714 to pending lawsuits. *Paramount*, 138 F.3d at 710 (1997) (QMB enactment appears to have been "designed to change the original statute in order to reduce the cost of Medicaid to the federal government").

The QMB patients for whom services have been provided are beneficiaries of Medicare, a wholly federal program. The federal government is inextricably involved in the programs at issue, and will benefit financially from the Ninth Circuit's uncritical deference to the congressional "clarification."

Retroactive application of any statute is limited by the Constitution. *See Landgraf v. USI Film Products*, 511 U.S. 244, 267 (1994) (citing provisions other than Article III). Basic separation of powers principles require an exception here to the general rule that courts must apply the law in existence at the time of decision to "pending" cases. Were it not so, few, if any, obstacles to congressional interference with the judicial function would exist. Unfettered application of § 4714 here will, as in *Klein*, effectively determine the outcome of particular cases pending against the federal government and resolve them in the government's favor to its significant financial benefit.

The Ninth Circuit, in deferring to the congressional act, ignored these principles and, in so doing, created an exception to the Constitution that has no basis in this Court's interpretation of Article III. Certiorari should be granted in light of continuing controversy over the meaning of *Klein*, particularly when applied, as here, to an issue capable of recurring in every cycle of budgetary

legislation. *See Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 47-48 (1977).

III. THE NINTH CIRCUIT BELOW IGNORED THE CONSTITUTIONAL CONTRACT CLAUSE, TAKINGS, AND DUE PROCESS PROBLEMS CREATED BY DEFERENCE TO THE CONGRESSIONAL "CLARIFICATION".

The Ninth Circuit's opinion below barely acknowledged, and did not address, the serious Fifth Amendment takings and due process and Contract Clause issues raised by Congress' effort to label Section 4714 as a "clarification" of prior law and California's certain action in reliance on it. Instead of considering these issues as a factor which might militate against judicial deference to the legislature, the court below found that it must "honor Congress' 'clarification' label . . . [which] moots all of appellees' constitutional objections to the new legislation." App. 15a; 132 F.3d at 1266. In so doing, the Ninth Circuit swept away a long line of this Court's decisions invalidating efforts by Congress to repudiate the contractual obligations of the United States.

This Court recently reiterated that ordinary contract principles apply to government agreements and that the federal government may not retroactively eliminate its own debts to save money. *See United States v. Winstar Corp.*, 116 S. Ct. at 2459-60 and n.28, 2464-65 and n.39, 2468, n.51 (plurality opinion), 2475-76 (Breyer, J., concurring), 2478-79 (Scalia, J., concurring); *see also Bowen v. Public Agencies Opposed to Social Security Entrapment*, 477 U.S. 41, 55 (1986). This Court noted that the most protectable of government contracts with private parties are those in procurement or similar situations. *Winstar*, 116 S.Ct. at 2457. Here, both the procurement and the rendition of services by contractors (the Physicians) had already been completed under existing law.

Section 4714 existinguishes obligations due and owing under prior law. Even Congress recognized that the services here have already been provided. See BBA § 4714(c) (App. 35a) (amendments "shall also apply to payment by a State for items and services furnished before" date of enactment if subject of a lawsuit). The law in effect when the Plaintiffs provided services, in 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p)(3), required payment to them at the Medicare rate—including Part B cost-sharing from state and federal Medicaid funds. *See Kozlowski*, 42 F.3d at 1459-60; *Haynes*, 36 F.3d at 1076-77; *Snider*, 29 F.3d at 894-95, 903; *Perales*, 954 F.2d at 809-63. Those rights were assigned to the Physicians as required by 42 U.S.C. § 1395w-4(g)(3)(A). The Physicians' rights to payment were vested.[5] An implied contract also arises after services are rendered under a law specifying compensation to be paid at the amount fixed. *See Robertson v. Miller*, 276 U.S. 174, 179 (1928). Rights under government contracts are properly protected by both the Due Process and Takings Clauses, as well as the Contract Clause as against a state. *See* App. 24a; *United States Trust Co. v. New Jersey*, 431 U.S. 1, 22, 29 (1977) (Contract Clause); *Thorpe v. Housing Authority*, 393 U.S. 268, 278 n.31

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[5] The Plaintiffs performed medical services for QMBs under "participation" agreements which obligated them to accept assignment of a Medicare beneficiary's right to payment, 42 U.S.C. § 1395u(h) (App. 25a), and limited them to recovery of 100 percent of the Medicare-approved charge. *See id.* § 1395u(b)(3)(B)(ii). Suppliers of services to QMBs are required to sign participation contracts. *Id.* § 1395w-4(g)(3)(A) (App. 26a). The Medicare Part B participation agreement for physicians contemplates that they will receive full payment, stating that a doctor "shall not collect from the beneficiary or other person or organization [such as an insurer] more than the applicable deductible and coinsurance." App. 50a. *See* 42 U.S.C. § 1320a-7b(d). The Physicians also had provider agreements with Medi-Cal, and the federal government had promised QMBs it would pay cost-sharing—a promise to which the Physicians were intended third-party beneficiaries. *See* App. 49a; *Britton v. Co-Op Banking Group*, 4 F.3d 742, 745 (9th Cir. 1993) (explaining third-party beneficiary law).

(1969) (due process); *Lynch v. United States*, 292 U.S. 571, 579 (1934) (takings); *Madera Irrig. Dist. v. Hancock*, 985 F.2d 1397, 1401 (CA9 1993) (takings); *Minnesota Assn. of Health Care v. Minn. Dept. of Pub. Welfare*, 742 F.2d 442, 450-51 (CA8 1984) (Contract Clause); *Caritas Services, Inc. v. Washington*, 869 F.2d 28, 41 (Wash. 1994) (Contract Clause); *Oberlander v. Perales*, 740 F.2d 116, 120 (CA2 1984) (due process); *but see Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 224 (1986) (leaving extent of protection by Takings Clause undecided).[6]

All four opinions in *Winstar* recognized similar rights as protectable against retroactive abrogation by the sovereign, relying on this Court's long-standing decisions in *Lynch*, 292 U.S. 571, and *Perry v. United States*, 294 U.S. 330 (1935), "the two principal cases of this century holding that the government may not simply repudiate its contractual obligations." *See id.* at 2478 (Scalia, J., concurring, joined by two justices); *see also* 116 S.Ct. at 2455, 2559-60 & n.28, 2464-65 & n.39, 2468-69 (plurality opinion); *id.* at 2473 (Breyer, J., concurring); *id.* at 2481 (Rehnquist, C.J., dissenting). Both *Lynch* and *Perry* make clear that congressional abrogation of the "essential bargain" of a contract is "impermissible repudiation." *Winstar*, 116 S.Ct. at 2479 (Scalia, J., concurring); *see Perry*, 291 U.S. at 435; *Lynch*, 292 U.S. at 580.

Through Section 4714, the United States and the State of California seek to retroactively avoid contractual rights even more worthy of protection than the prospective insurance benefits at issue in *Lynch*. *See* 292 U.S. at 580-81. The attempted avoidance violates both the takings clause and the due process guarantee of the Fifth Amendment and (as against California) the Contract Clause. *See*

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[6] Actions of state governments in a joint relationship involving federal action may be attributed to the United States for takings purposes. *See Preseault v. United States*, 100 F.3d 1525, 1551 (CA Fed. 1996) (en banc).

Lynch; *United States Trust Co.*; *Perry*; *cf. United States v. Larionoff*, 431 U.S. 864, 880 (1977) (intimating that Congress may not deprive service member of pay due for duties already performed). The benefit that the United States will derive from retroactive application of Section 4714 cannot be overlooked. "[I]t makes sense to scrutinize governmental action more closely when the State stands to benefit." *Harmelin v. Michigan*, 501 U.S. 957, 978 n.9 (1991) (citing *Perry*, 294 U.S. at 350-51). The United States will avoid the obligation to pay matching funds to the states through the effect of Section 4714, the CBO has reported. App. 41a.

The Ninth Circuit's failure to address these constitutional concerns elevates deference to a purported congressional clarification above the Physicians' vested property interests. Certiorari should be granted to re-establish the vitality of *Lynch* and *Perry* in these circumstances and to sustain the Physicians' Contract Clause rights.

IV. CERTIORARI SHOULD BE GRANTED TO RESOLVE THE CONFLICT IN THE CIRCUITS REGARDING THE STATES' OBLIGATIONS TO PAY MEDICARE COST SHARING ON BEHALF OF QMBS WITH RESPECT TO SERVICES RENDERED PRIOR TO AUGUST 5, 1997.

Although fairly implicated by Petitioners' request that this Court provide guidance as to the weight to be given to the retroactive budgetary "clarification" of the QMB payment provisions, it also is important for this Court explicitly to resolve the conflict thus engendered over the correct interpretation of the QMB provisions as they existed before the Balanced Budget Act.

As described above, the four Circuits held that the plain meaning of 42 U.S.C. § 1396a(a)(10)(E), requiring states to "make available" medical assistance for (i.e., to cover) "medicare cost-sharing," combined with the explicit definition of "medicare cost sharing" at 42 U.S.C. § 1396d (p)(3), was clear and did not permit the limitations urged

by the states and the Secretary. Consequently, the four Circuits rejected the Secretary's position that 42 U.S.C. § 1396a(n) allowed the states, at their option, to "make available" something less, or even nothing, and thereby to ignore and eviscerate § 1396a(a)(10)(E). The four Circuits collectively analyzed the statutory scheme at length and concluded that the Secretary's position was due no deference under *Chevron* principles. *See Kozlowski*, 42 F.3d at 1446-60; *Snider*, 29 F.3d at 888-903; *Haynes*, 36 F.3d at 1076-77; *Perales*, 954 F.2d at 856-63.

The Seventh and Ninth Circuits, with far less analysis of the statute, and expressly influenced by the later Congress' view that the four Circuits had misinterpreted the statutory language of the enacting Congress, found that the original statutes were ambiguous and that the Secretary's interpretation, as "clarified" by Congress, should prevail. Neither court discussed the meaning of 42 U.S.C. §§ 1396a(a)(10)(E) or 1396d(p)(3) in detail, the Ninth Circuit specifically electing to "eschew any analysis" of the statutes without even any citation to them. *See Beverly Comm. Hosp.*, 132 F.3d at 1264; App. 10a; *see also Paramount*, 138 F.3d at 707-09.

Although inextricably intertwined with the question of deference to the later enactment, the conflict in the circuits undermines this Court's foundational rules of statutory construction that enactments are to be given their plain meaning and the words of the statute are deemed the best indicators of congressional intent. *See e.g., Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-254 (1992); *Richards v. United States*, 369 U.S. 1, 9 (1962). Likewise, the conflicting interpretations distort this Court's teaching that if legislative history must be consulted, it is the intent of the enacting Congress, not the opinions of a subsequent one, that is controlling. *See Pierce v. Underwood*, 487 U.S. 552, 566-67 (1988) (commenting, in this context, that interpretation of enacted statute is a function of the courts "and not the legislature"); *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979). Certiorari

should be granted to resolve the conflict among the circuits.

CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to review the judgment of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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APPENDIX

APPENDIX

APPENDIX

UNITED STATES COURT OF APPEALS
NINTH CIRCUIT

Nos. 97-55022, 96-55208, 97-55713, 96-56249, 96-56485, 96-56648, 96-56699 and 96-56745

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, a California non-profit public benefit corporation, d/b/a Beverly Hospital; BELLWOOD MEDICAL CORPORATION, d/b/a Bellwood General Hospital; CHICO COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a Chico Community Rehabilitation Hospital, d/b/a Chico Community Hospital; HOLLYWOOD COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a Hollywood Community Hospital Of Van Nuys, d/b/a Hollywood Community Hospital Of Hollywood; LANCASTER HOSPITAL CORPORATION, d/b/a Lancaster Community Hospital, *et al.*,
Plaintiffs-Appellees,

v.

KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendant-Appellant.

CALIFORNIA AMBULANCE ASSOCIATION,
Plaintiff-Appellee,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services,
Defendant,

and

KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendant-Appellant.

CALIFORNIA AMBULANCE ASSOCIATION,
Plaintiff-Appellee,

v.

DONNA E. SHALALA, Secretary of United States Department of Health and Human Services,
Defendant-Appellant.

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants-Appellants.

RICHARD GILMORE, M.D.; PRATAP SARAF, M.D.,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Resources,
Defendant,

S. KIMBERLY BELSHE, Director of Health Services,
Defendant-Appellant.

RICHARD GILMORE, M.D., individually and on behalf of all those similarly situated; PRATAP SARAF, M.D., individually and on behalf of all those similarly situated,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Ph.D., Secretary of the United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants-Appellants.

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Sesources,
Defendant-Appellant.

DONALD R. MACPHERSON, JR., as Successor in interest to decedent Christina MacPherson & MacPherson Oil Company Employee Welfare Benefit Plan,
Plaintiff-Appellant,

v.

EMPLOYERS HEALTH INSURANCE,
Defendant-Appellee.

Appeal from the United States District Court
for the Central District of California
J. Spencer Letts, District Judge, Presiding
D.C. Nos. CV-95-04053-JSL, CV-96-02322-JSL,
CV-96-2322-JSL, CV-03033-JSL, CV-96-05564-JSL,
CV-96-03033-JSL, CV-97-00514-JSL

Argued and Submitted Oct. 6, 1997
Decided Dec. 2, 1997

Before: REINHARDT and TASHIMA, Circuit Judges, and SHADUR, District Judge.*

SHADUR, District Judge:

We address here a question of first impression, not only in this Circuit but (understandably in light of the recency

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* The Honorable Milton I. Shadur, United States District Judge for the Northern District of Illinois, sitting by designation.

of the legislation involved) in any court: whether a congressional enactment adopted in August 1997, but stating that it is retroactive and applicable to pending cases, calls for approval of the reading that has been given to the pre-enactment version of the same legislation by the Secretary of the United States Department of Health and Human Services ("Secretary"). Because we answer that question in the affirmative, we reverse all three decisions below.[1]

All three of these sets of appeals pose a common problem: whether the State of California may choose to limit certain payments, as required by statute to be made to enroll poor people—qualified Medicare beneficiaries ("QMBs")—in the Medicare insurance program, to the amount by which California's Medicaid rate exceeds what Medicare has paid. Those payments, required from all participating states under the Medicaid Act, extend to deductibles, coinsurance and copayments that the QMBs cannot bear fully and that the State is required to pay on their behalf (whether totally or in part is at stake in these cases).

Title XVIII of the Social Security Act (the "Medicare Act," 42 U.S.C. §§ 1395-1395ccc[2]) provides a federal health insurance program for elderly and disabled persons. Medicare Part A covers inpatient hospital services and certain related benefits (Sections 1395c-1395i-4), and it is provided automatically for individuals entitled to Social Security retirement or disability benefits (Section 426). Medicare Part B is a voluntary program under which Medicare-eligible persons can obtain supplemental insurance for various outpatient services from physicians and other providers(Sections 1395j-1395w-4). It is financed

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[1] In each instance the jurisdiction of the district court was based upon 28 U.S.C. § 1331. All three judgments are appealable pursuant to 28 U.S.C. § 1291.

[2] All further citations to Title 42 provisions will take the form "Section-," utilizing the Title 42 numbering system rather than the internal numbering of the Acts involved.

by a combination of federal funds and premiums paid by or on behalf of eligible individuals (Sections 1395r, 1395t (g)). Both Medicare Part A and Medicare Part B call for payments by covered individuals that constitute the deductibles, coinsurance and copayments referred to earlier.

Title XIX of the Social Security Act (the "Medicaid Act," Sections 1396-1396v) is a cooperative federal-state program that provides federal matching funds to states that elect to provide medical services to certain needy individuals (see Section 1396; *Harris v. McRae*, 448 U.S. 297, 301, 100 S.Ct. 2671, 2680, 65 L.Ed.2d 784 (1980)). Although states are not required to participate in Medicaid, if they elect to do so they must follow federal guidelines (*Harris*, 448 U.S. at 301, 100 S.Ct. at 2680) and must submit for Secretary's approval their state plans that describe the states' intended means for insuring compliance with those guidelines (Section 1396a(b)).

What is at issue in these three sets of appeals is the area of overlap between the Medicare and Medicaid Acts where coverage for the elderly poor is involved. Those persons are often entitled to participate in such coverage but may not be able to afford to pay the required deductible and coinsurance amounts under Medicare Part A or the premiums and payments needed to enroll in Medicare Part B. At the time that the various lawsuits were filed below, Congress had dealt with individuals who are eligible for both Medicare and Medicaid (see Section 1396d (p)(1)) by stating in Section 1396a(n) of the Medicaid Act what the state plans could set up to cover their obligations on behalf of the QMBs involved.

Three types of plaintiffs (now appellees) are involved in these appeals. *Beverly Hospital* is a class action on behalf of all California hospitals that provide inpatient hospital services under the Medicare and Medicaid Acts. *California Ambulance* involves two types of associations, California Ambulance Association and physician associations including California Medical Association, each type

of association also representing providers of services under the two statutes. And *Gilmore* was brought by two doctors who provide outpatient physician services to persons under the two statutes.[3] Thus *Beverly Hospital* involves Medicare Part A, while *California Ambulance* and *Gilmore* implicate Medicare Part B.

Secretary is an appellant in all of the cases except for *Beverly Hospital,* in which she was given leave to participate as an amicus curiae. Director S. Kimberly Belshe of the California Department of Health Services ("Director") is an appellant in all of the cases. Both appellants subscribe to Secretary's legal position pursuant to which California adopted its Medicaid state plan ("Medi-Cal"), which position asserts that under Section 1396a(n) participating States such as California have the choice to limit their payments as described earlier, so that they need not pay the *full* cost-sharing amount. In each of the cases before us the District Court rejected that contention, as have all four Courts of Appeals that have addressed the question: *Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski,* 42 F.3d 1444 (4th Cir.1994) ("*Kozlowski*"); *Haynes Ambulance Serv., Inc. v. State of Alabama,* 36 F.3d 1074 (11th Cir.1994 ("*Haynes*"); *Pennsylvania Med. Soc'y v. Snider,* 29 F.3d 886 (3d Cir.1994) ("*Snider*"); and *New York City Health and Hosps. Corp. v. Perales,* 954 F.2d 854 (2d Cir.1992) ("*Perales*").[4]

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[3] Although the *Gilmore* case was originally intended to be a class action, any need for class certification was obviated when defendants agreed that the result in the case would be followed as to all persons providing such services.

[4] Although this does not affect our resolution of these cases in light of what follows, it is worth noting that those four Courts of Appeals have employed divergent approaches (reading the statute differently) in reaching their conclusions. And it may be added that those four decisions (and the decisions now on appeal) do not at all reflect a unanimous judicial reaction: For example, two recent District Court decisions, *Dameron Physicians Med. Group v. Shalala,* 961 F.Supp. 1326 (N.D.Cal.1997) and *Kulkarni v. Leean,*

After the scheduled briefing of these appeals had been completed, Congress entered the picture. Its Balanced Budget Act of 1997 ("Act"), signed into law by the President on August 5 of this year, included as Act § 4714 a provision that expressly amends Section 1396a(n) to adopt the position advanced by Secretary and Director here:

> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.
>
> (3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)-
>
> > (A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;
> >
> > (B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and
> >
> > (C) any lawful sanction that may be imposed upon a provider or such an organization for

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No. 96 C 884-S, 1997 WL 527674 (W.D. Wis. June 23), have joined other lower court decisions going the other way. See also the discussion of the problem at 66 U.S.L.W. 2233 (Oct. 21, 1997).

> excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.
>
> This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

There is no dispute among the litigants that if this new statutory provision (which Congress has captioned "Clarification Regarding State Liability for Medicare Cost-Sharing") is applicable, it requires the reversal of the District Court's decisions. One minor variant exists: Beverly Hospital contends that a remand is necessary because Secretary's methodology, as applied to that hospital's situation, does not mesh with the new enactment. We speak briefly to that question later.

Because Congress was deliberately targeting what were known to be existing disputes on this subject, Act § 4714 (c) went on to prescribe a retroactive effective date of the quoted amendment:

> (c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act [5] and that is pending as of, or is initiated after, the the date of the enactment of this Act.

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[5] Those cited sections of the Social Security Act respectively correspond to Sections 1396a(n) and 1396d in the Title 42 usage employed in this opinion. Those sections are in fact the statutory provisions involved in these appeals.

That being the case, the relevant considerations in our three cases have shifted from those that had occupied the parties' entire scheduled briefing, which (as stated earlier) had been completed before the congressional enactment. We therefore invited and received supplemental briefing on the effect of Act § 4714 on these cases. And having done so, we eschew any analysis of those original arguments and turn instead to the validity and applicability of the August 1997 enactment.

Standard of Review

Both because constitutional questions are at issue and because the cases come up on summary judgment, we engage in a de novo review of the district courts' final judgments (*Gray v. First Winthrop Corp.*, 989 F.2d 1564, 1567 (9th Cir.1983) ("The constitutionality of a statute is a question of law which we review de novo"); *Brinson v. Linda Rose Joint Venture*, 53 F.3d 1044, 1047 (9th Cir. 1995) (holding that an order granting summary judgment is reviewed de novo). Each of the issues before us will be examined through that lens.

Application of Act § 4714

At the outset we examine the coverage of these appeals by the new legislation—a matter that was challenged in the appellees' briefs but was not addressed by their counsel during oral argument. As the earlier-quoted Act § 4713 (c) states, the new amendments apply to any payments by a State for items and services furnished pre-enactment as long as the payment "is the subject of a lawsuit . . . that is pending as of . . . the date of the enactment of this Act." In that respect it does not matter whether the congressional labeling of the new legislation as simply a "clarification" has to be credited by a court (a subject that we deal with in a moment). What is instead significant is that Congress' characterization plainly reflects its intention to resolve every still-live dispute in the manner

specified by the new legislation. Hence the statutory reference to "pending" lawsuits must be construed as embracing not only undecided cases at the District Court level but also actions pending on appeal, such as the ones before us.

We have previously ascribed precisely that meaning to the term "pending" in *Gray*, 989 F.2d at 1571. There we cited and quoted from numerous earlier decisions upholding Congress' power to impact the results in cases still "pending" on appeal without running afoul of separation of powers principles:

> These cases are properly construed as "pending" cases for separation of powers purposes. *See Griffith v. Kentucky*, 479 U.S. 314, 321 n. 6, 107 S.Ct. 708, 712 n. 6, 93 L.Ed.2d 649 (1987) (judgment is "final" and case is no longer pending only after "the availability of appeal [is] exhausted, and the time for a petition for certiorari [has] elapsed or a petition for certiorari finally [has been] denied"); *see also Georgia Ass'n of Retarded Citizens v. McDaniel*, 855 F.2d 805, 813 (11th Cir.1988) ("When it so intends, [Congress'] ability to affect the content of a nonfinal judgment in a civil case, through retroactive legislation ceases only when a case's journey through the courts comes to an end."), *cert. denied*, 490 U.S. 1090, 109 S.Ct. 2431, 104 L.Ed.2d 988 (1989); *de Rodulfa v. United States*, 461 F.2d 1240, 1253 (D.C. Cir.) ("[T]he suit is pending until the appeal is disposed of, and until disposition any judgment appealed from it is still *sub judice*.") (internal quotations omitted), *cert. denied*, 409 U.S. 949, 93 S.Ct. 270, 34 L.Ed. 220 (1972).

And what *Gray, id.* then said, albeit in the different context of a change in a statute of limitations, applies with equal force to give identical content to the word "pending" in Act § 4714(c):

> Because none of the cases here have completed their journey through the appellate process, Congress has the authority to change the underlying substantive law by altering the statute of limitations in a way that affects those pending cases.

Because Congress thus has such authority to *change* the law as to pending cases, its power to *clarify* the law—to confirm what the law has always meant—follows a fortiori.

That being the case, the next line of inquiry is whether the new enactment is valid in its application to such pending cases. On that score a key threshold issue is whether the enactment was truly a "clarification" of the prior statute (as Congress said), or was instead a substantial change in the law. If Act § 4714 were to be characterized in the latter fashion, its retroactive application would pose a series of potential constitutional problems. If however Act § 4714 merely clarifies what Section 1396a(n) was originally intended to mean, then the Medicaid Act never required states such as California to pay cost-sharing in full. In that event the only function of Act § 4714 in this situation is to state more clearly what the law already was —it has no retroactive effect that might be called into constitutional question. Because appellees do not dispute the constitutionality of the prospective application of Act § 4714, if that provision merely clarifies Section 1396a (n) there are also no potential constitutional problems with the application of the enactment to these pre-Act cases.

As already indicated, Congress expressly (and formally) stated as its intention that the new provision in Act § 4714 was a "clarification" of the payment rules contained in Section 1396a(n). It has been established law since nearly the beginning of the republic (as demonstrated by *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381-82 & n. 8, 89 S.Ct. 1794, 1801-02 & n. 8, 23 L.Ed.2d 371 (1969) and earlier cases cited there) that congres-

sional legislation that thus expresses the intent of an earlier statute must be accorded great weight (see most recently *Loving v. United States*, 517 U.S. 748, ——, 116 S.Ct. 1737, 1749, 135 L.Ed.2d 36 (1996), quoting the *Red Lion* language as earlier repeated in *Consumer Product Safety Comm'n v. GTE Sylvania*, 447 U.S. 102, 118 n. 13, 100 S.Ct. 2051, 2061 n. 13, 64 L.Ed.2d 766 (1980); and see also the plurality opinion in *United States v. Winstar Corp.*, 518 U.S. 839, ——, 116 S.Ct. 2432, 2463, 135 L.Ed.2d 964 (1996) (speaking in terms of "signficant weight")).

Other cases that question the competence of a later Congress to opine on the intended meaning of an earlier statute are readily distinguishable. All of those cases have involved attempts to use less formal types of subsequent legislative history, particularly Senate and House Committee Reports, to infer the meaning of prior enactments (*United States v. Southwestern Cable Co.*, 392 U.S. 157, 170, 88 S.Ct. 1994, 20 L.Ed.2d 1001 (1968), rejecting the use of congressional opinions contained solely in House Committee Reports; *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758, 99 S.Ct. 2066, 2072-73, 60 L.Ed.2d 609 (1979), rejecting the use of congressional opinions expressed only in Senate report; and see *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 839-40, 108 S.Ct. 2182, 2190-91, 100 L.Ed.2d 836 (1988), rejecting the use not only of a later House Committee Report but also of the later enactment as such as bases for ininferring the intent of an earlier Congress). By contrast, here Congress has formally declared Act § 4714 to be a clarification of Section 1396a(n) in the title of the Act as well as in the Committee Reports.[6] Such formal legislative

[6] While titles of acts are not part of the law, they can be used to resolve ambiguity in a statute, so long as they do not contradict the actual text (see, e.g., *INS v. National Ctr. for Immigrants' Rights, Inc.*, 502 U.S. 183, 189, 112 S.Ct. 551, 555-56, 116 L.Ed.2d 546 (1991) and cases cited there). In this instance, the congressional

action squarely fits the *Red Lion* mold as so often (and so recently) reconfirmed by later cases, so that Act § 4714 is entitled to great weight in construing the meaning of Section 1396a(n).

Appellees contend that Act § 4714 effected such a substantial change in federal law in terms of the government's liability to health care providers that it cannot be treated as simply clarifying Section 1396a(n). But that argument proceeds from the premise that Section 1396a(n)'s meaning was clear enough so as to need no further explanation. Not only does that premise ignore the split of authority construing the statute (though to be sure the four Court of Appeals opinions have uniformly rejected Secretary's reading), but even more significantly any quality of crystal clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes (thus even one of the cases relied on by appellees, *Kozlowski,* 42 F.3d at 1450, has pungently—and accurately—characterized the provisions detailing Medicaid and Medicare financing as "among the most completely impenetrable texts within human experience").

Section 1396a(n) is a superb example of the baffling nature of the statute. It has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification. While one battle has raged (with mixed results) over whether to accept Secretary's construction of the provision, even the courts that have rejected Secretary's approach have not expressed a single construction of the statute (compare *Kozlowski,* 42 F.3d at 1454, reading Section 1396a(n) to allow a state to exercise the option to pay more for a QMB than for a dual-eligible person; *Perales,* 954 F.2d at 859, stating "it appears that the reason that section a(n) authorizes

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title, rather than merely resolving an ambiguity, parallels the provision in Act § 4714(c) that specifically makes the statute applicable to pre-Act services involved in pending litigation.

payment beyond the Medicare amount, when it is required by another section, is to clarify that the Medicaid Act does not prohibit a provider from accepting more than the "Medicaid rate"; and *Snider*, 29 F.3d at 895, holding that Section 1396a(n) "authorizes the states to deviate from their schedules or payment methods with respect to QMB Part B cost-sharing payments, thus carving out an exception to the general requirement to comply with the Medicaid fee schedules or payment methods"). Only *Haynes*, 36 F.3d at 1076, by following the interpretation established in *Snider*, avoids the spectre of four Courts of Appeals reaching the same result for four (rather than three) different reasons. Congress noted the existing confusion when it made the statement (really an understatement) that the amount that states were required to pay on behalf of QMBs was "the subject of some controversy" (H. Conf. Rep. No. 105-217, 143 Cong. Rec. H6252 (daily ed. July 29, 1997)).

Given the extraordinary difficulty that the courts have found in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of Section 1396a(n) is worthy of real deference. Appellees' arguments that Act § 4714 is new law, despite Congress' unambiguous title for that section, cannot override that deference, because those arguments incorrectly presume a clearly established meaning for Section 1396(n)—something that simply did not exist before Act § 4714 was adopted.

We therefore honor Congress' "clarification" label and accept Act § 4714's provisions as a statement of what Section 1396a(n) has meant all along. That moots all of appellees' constitutional objections to the new legislation, because those objections rest entirely on the assertedly retroactive, rather than declaratory, nature of Act § 4714. But it is worth adding that we have, en route to our decision, carefully explored the litigants' arguments both as to the pre-Act version of Section 1396a(n) and

as to the constitutional issues raised by appellees if Act § 4714 were to be viewed as a retroactive change in, rather than a declaratory clarification of, the prior law—questions implicating the separation of powers, the Contract Clause and the Due Process Clause. And that exploration, which necessitated an effort on our part to parse the intricate and complex provisions of the pre-Act legislation, has only deepened our conviction that Congress' stated intention of clarifying that pre-existing law should be credited.

That leaves only one tag end for discussion, a statutory claim raised by the plaintiff Association in No. 96-55208 ("Beverly") that is unique to it as a provider of inpatient medical services to QMBs under Medicare Part A. Beverly argues in its supplemental brief that Medi-Cal's methodology for reimbursing hospitals for their Medicare expenses under Part A is not legal under either Beverly's or Secretary's interpretation of Act § 4714 (a)(2). Beverly urges this Court to affirm the district court's ruling below on that ground (under the familiar principle, as repeated in *Herring v. FDIC*, 82 F.3d 282, 284 (9th Cir. 1995), that an appellate court may uphold a ruling on any basis that the record supports, even if it was not considered by the lower court).

But before an appellate court will consider such an issue, ordinarily the argument must have been raised sufficiently for the trial court to rule on it (*A-1 Ambulance Serv. v. County of Monterey*, 90 F.3d 333, 338 (9th Cir.1996), citing *In re E.R. Fegert Inc.*, 887 F.2d 955, 957 (9th Cir.1989)). In this instance Beverly initially cited a single excerpt from the trial court record that it said had raised the statutory issue about Medi-Cal's Medicare Part A reimbursement policies. But post-argument its counsel has clarified its position as presenting a different assertion: that its current argument could not have been made below because it arose only as a result of standards set forth in the later-enacted Section 4714 (a)(1), now codified as Section 1396a(n)(2).

We need not resolve that newly-raised contention, nor does it call for a remand rather than a reversal. Any claim that California is violating the new federal statute—something that is necessarily not encompassed within the scope of the record as it was presented to the trial court and is thus not on review in the appeal before us—really represents the basis for a new lawsuit. Any such claim would call for the generation of a new record, against which a trial court could determine in the first instance whether there is anything to the contention that Act § 4714's clarification of the prior law somehow renders the Medi-Cal reimbursement methodology for hospitals under Medicare Part A invalid. And in that respect the trial court would also have to determine whether despite the existence of the new enactment, Beverly's argument on that score is one that it could perhaps have raised the first time around, so that it might be held to have forfeited the argument by virtue of its not having done so in this original litigation.

Conclusion

For the reasons that we have stated here at some length, we conclude that Act § 4714 is a clarification of the original intent of Congress when it passed Section 1396a(n). That being the case, the district courts' orders granting summary judgment in favor of each appellee are REVERSED. As a final point, we note that Director Belshe has not requested a remand in order to seek to recoup any excessive payments made pursuant to the district court's orders. We indicate no view as to her right to obtain any such relief.

[Filed Mar. 3, 1998]

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 96-55208

D.C. No. CV 95-4053 JSL

BEVERLY COMMUNITY HOSPITAL ASS'N
Plaintiff-Appellee,

v.

S. KIMBERLY BELSHE, Director of the California Dep't of Human Services,
Defendant-Appellant.

Nos. 96-56249
96-56485
96-56648
97-55022

D.C. Nos. CV-96-2322-JSL
CV-96-3033-JSL

CALIFORNIA AMBULANCE ASS'N,
CALIFORNIA MEDICAL ASS'N, *et al.*,
Plaintiffs-Appellees,

v.

S. KIMBERLY BELSHE, Director of the California Dep't of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services,
Defendants-Appellants.

Nos. 96-56699
96-56745
97-55713
97-55220

D.C. No. CV-96-5564 JSL

RICHARD GILMORE, *et al.*,
Plaintiffs-Appellees,
v.
S. KIMBERLY BELSHE, Director of the California Dep't of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services,
Defendants-Appellants.

ORDER

Before: REINHARDT and TASHIMA Circuit Judges, and SHADUR, District Judge.**

The panel has voted to deny the petitions for rehearing and to reject the suggestions for rehearing en banc. The full court has been advised of the suggestion for rehearing en banc, and no judge of the court has requested a vote on the suggestions for rehearing en banc. Fed. R. App. P. 35(b).

The petitions for rehearing are denied and the suggestions for rehearing en banc are rejected.

** The Honorable Milton I. Shadur, Senior United States District Judge for the Northern District of Illinois, sitting by designation.

[Filed Dec. 16, 1996]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Case No. CV 96-5564 JSL

RICHARD GILMORE, M.D. and PRATAP SARAF, M.D., individually, and on behalf of all those similarly situated,
Plaintiffs,

v.

DONNA SHALALA, Secretary of the United States Department of Health and Human Services, and S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants.

FINAL JUDGMENT

Having reviewed the papers filed in connection with this matter, and being fully appraised of the relevant facts and law, on the Court's own motion, the Court hereby finds and determines as follows:

A. This Court has granted judgment in favor of the plaintiffs in *California Medical Association v. Donna Shalala, et al.*, Case No. CV 96-3033; *California Ambulance Association v. Donna Shalala, et al.*, Case No. CV 96-2322; and *Beverly Community Hospital Association v. Belshe*, Case No. CV 95-4053, all of which raise similar or identical issues of fact and law.

B. Under the Medicare and Medicaid Acts, including but not limited to 42 U.S.C. § 1396a(a)(10)(E):

1. Plaintiffs are entitled to compensation for medical and other health services rendered to QMBs at 80% of

the Medicare allowable rate plus the full Medicare Part B cost-sharing amount;

2. Plaintiffs' compensation for medical and other health services rendered to QMBs is not limited by the Medi-Cal reimbursement rate for such services; and

3. The Medi-Cal Program as administered by defendant Belshe and approved by defendant Shalala, California Welfare & Institutions Code Section 14109.5, and the Medi-Cal Program's implementing bulletins and regulations, to the extent that they reduce or eliminate payment or reimbursement by Medi-Cal of the full Medicare Part B cost-sharing amounts for medical and other health services furnished to QMBs, violate federal law and Plaintiffs' rights under 42 U.S.C. § 1983.

Based on the foregoing findings and for good cause appearing therefor,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that judgment be, and hereby is, entered in favor of the named Plaintiffs and against Defendants as follows:

1. Defendants and their successors, officers, agents, servants and employees are permanently enjoined from approving, allowing to be implemented, and enforcing the Medi-Cal Program, including California Welfare & Institutions Code Section 14109.5 and implementing bulletins and regulations, to the extent that they violate federal law by (1) preventing Plaintiffs from receiving compensation for medical and other health services provided to QMBs at the rates appropriate under federal law, and (2) reducing or eliminating payment or reimbursement by Medi-Cal of the full Medicare Part B cost-sharing amount for medical and other health services provided to QMBs.

2. Defendants shall pay Plaintiffs' attorneys' fees in a sum to be determined after determination of any appeal by Defendants or the time for defendants to file an appeal has expired.

DATE: 12/16/96

/s/ J. Spencer Letts
HONORABLE J. SPENCER LETTS
United States District Judge

Submitted by:

GREENBERG, GLUSKER, FIELDS,
CLAMAN & MACHTINGER LLP

By: /s/ Michael A. Greene
MICHAEL A. GREENE
Attorneys for Plaintiffs
Richard Gilmore, M.D. and
Pratap Saraf, M.D.

[Filed Sep. 24, 1996]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CV96-5564 JSL

RICHARD GILMORE, M.D. and PRATAP SARAF, M.D.
Plaintiffs,

v.

DONNA SHALALA, *et al.*,
Defendants.

JUDGMENT

Having reviewed the papers filed in connection with this matter, having heard oral argument, and being fully apprised of the relevant facts and law, on the Court's own motion IT IS HEREBY ORDERED AND ADJUDGED that judgment be entered for the plaintiffs based on the complaint. This case appears to raise no new issues of fact and law than those already determined by the Court in *California Ambulance Association v. Donna Shalala, et al.*, CV96-2322; *California Medical Association v. Donna Shalala et al.*, CV96-3033; and *Beverly Community Hospital Association v. Belshe*, CV 95-4053. If either party feels that this action does present a question of law and fact not addressed in the Court's three earlier rulings, they are granted leave to file a motion to reconsider. The Court requests that the plaintiffs submit a final order and judgment. By granting judgment for the plaintiffs on the basis of the pleadings, the Court does not expect that there will be motion for attorney fees. The Court may amend or amplify this order with a more specific statement of the grounds for its decision.

IT IS SO ORDERED.

Dated: 9/24/96

/s/ J. Spencer Letts
J. SPENCER LETTS
United States District Judge

CONSTITUTIONAL PROVISIONS

U.S. Const., art. I, § 10 (first paragraph)

No State shall enter into any Treaty, Alliance, or Confederation; grant letters of Marque and Reprisal; coin Money; emit Bills of Credit; make any Thing but gold and silver Coin a Tender in Payment of Debts; pass any Bill of Attainder, ex post facto Law, or Law impairing the Obligation of Contracts, or grant any Title of Nobility.

U.S. Const., art. III, § 1. Judicial Power, Tenure and Compensation

The judicial Power of the United States, shall be vested in one Supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office.

U.S. Const., amend. V.

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

STATUTES

Amendments enacted pursuant to § 4714 of the Balanced Budget Act of 1997 are set forth in [bracketed] italics.

42 U.S.C. § 1395l. Payment of benefits

(a) Amounts

Except as provided in section 1395mm of this title and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of an individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1395k (a)(1) of this title—80 percent of the reasonable charges for the services; except that . . . (N) with respect to expenses incurred for physicians' services (as defined in section 1395w-4(j)(3) *of* this title, the amounts paid shall be 80 percent of the payment basis determined under section 1395w-4(a)(1) of this title, . . .

42 U.S.C. § 1395u. Use of carriers for administration of benefits

(h) Participating physician or supplier; agreement with Secretary; publication of directories; availability; inclusion of program in explanation of benefits; payment of claims on an assignment related basis

(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term "participating physician or supplier" means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984,

enters into an agreement with the Secretary which provides that such physician or supplier will accept payment under this part on an assignment-related basis for all items and services furnished to individuals enrolled under this part during such year. . . .

42 U.S.C. § 1395w-4. Payment for physicians' services

(a) Payment based on fee schedule

(1) In general

Effective for all physicians' services (as defined in subsection (j)(3) of this section) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1395m(b) of this title, payment under this part instead shall be based on the lesser of—

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) of this section for services furnished during that year (in this subsection referred to as the "fee schedule amount").

(g) Limitation on beneficiary liability

(3) Limitation on charges for medicare beneficiaries eligible for medicaid benefits

(A) In general

Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1396d(p)(1) of this title) with respect to such services under a State plan approved under subchapter XIX of this chapter may only be made on an assignment-related basis [*and the provisions of sec-*

tion 1396a(n)(3)(A) apply to further limit permissible charges under this section].

42 U.S.C. § 1396a. State plans for medical assistance

(a) Contents

A state plan for medical ascistance must—

(10) provide—

(E)(i) for making medical assistance available for medicare cost sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title; . . .

except that . . . (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) of this section and 1396o(b) of this title,

(n) Payment amounts

[*(1)*] In the case of medical assistance furnished under this subchapter for medicare cost sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

[*(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred*

relating to payment for deductibles, coinsurance, or co-payments for medicare cost-sharing to the extent that payment under subchapter XVIII for services would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

(A) for purposes of applying any limitation under subchapter XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under subchapter XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1396a(m)(1)(A) for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this subchapter or subchapter XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.]

42 U.S.C. § 1396b. Payment to States

(b) Quarterly expenditures beginning after December 31, 1969

(1) Notwithstanding the preceding provisions of this section, the amounts determined under subsection (a)(1) of this section for any State for any quarter beginning

after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 and over and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of subchapter XVIII of this chapter, other than amounts expended under provisions of the plan of such State required by section 1396a(a)(34) of this title.

42 U.S.C. § 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provisions;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

42 U.S.C. § 1396d. Definitions

For purposes of this subchapter—

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to section 1396u-3 of this title, the term "Federal medical assistance percentage" for any State shall be

100 per centum less the the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum. . . .

(p) Qualified medicare beneficiary; medicare cost sharing

(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395i-2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i-2 of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1382a of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

(3) The term "medicare cost sharing" means [*(subject to section 1396a(n)(2) of this title)*] the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items or services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1395i-2 or 1395i-2a of this title, and

(ii) premiums under section 1395r of this title,

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e and section 1395*l*(b) of this title).

(D) The difference between the amount that is paid under section 1395*l*(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of the State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

REGULATIONS

42 C.F.R. § 400.202 Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

. . .

Payment on an assignment-related basis means payment for Part B services—

(1) To a physician or other supplier that accepts assignment from the beneficiary, in accordance with § 424.55 or § 424.56 of this chapter;

(4) For services furnished by a person or entity other than those specified in paragraphs (b)(1) through (b)(3) of this section, 80 percent of the reasonable charges or 80 percent of the amount computed on any other payment basis for the services.

42 C.F.R. § 424.55 Payment to the supplier.

(a) Medicare pays the supplier for covered services if the beneficiary (or the person authorized to request payment on the beneficiary's behalf) assigns the claim to the supplier and the supplier accepts assignment.

(b) In accepting assignment, the supplier agrees to the following:

(1) To accept, as the full charge for the service, the amount the carrier determines to be the reasonable charge.

(2) To limit charges to the beneficiary as follows:

(i) To collect nothing for those services for which Medicare pays 100 percent of the reasonable charge.

(ii) To collect only the amount of the unmet deductible, plus 20 percent of the difference between the reasonable charge and the unmet deductible for those services for which Medicare pays 80 percent of that difference.

105th Congress
1st Session

Report
105-217

HOUSE OF REPRESENTATIVES

BALANCED BUDGET ACT OF 1997

CONFERENCE REPORT
TO ACCOMPANY
H.R. 2015

* * * *

TITLE IV—MEDICARE, MEDICAID, AND CHILDREN'S HEALTH PROGRAMS
Subtitle H—Medicaid
Chapter 2—Flexibility In Payment of Providers

SEC. 4714. MEDICAID PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING.

(a) CLARIFICATION REGARDING STATE LIABILITY FOR MEDICARE COST-SHARING.—

(1) IN GENERAL.—Section 1902(n) (42 U.S.C. 1396a(n)) is amended—

(A) by inserting "(1)" after "(n)", and

(B) by adding at the end the following:

"(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

"(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

"(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

"(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for for the service; and

"(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.".

(2) CONFORMING CLARIFICATION.—Section 1905 (p)(3) (42 U.S.C. 1396d(p)3)) is amended by inserting "(subject to section 1902(n)(2))" after "means".

(b) LIMITATION ON MEDICARE PROVIDERS.—

(1) PROVIDER AGREEMENTS.—Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended—

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the comma at the end the following: ", and (ii) not to impose

any charge that is prohibited under section 1902(n)(3)".

(2) NONPARTICIPATING PROVIDERS.—Section 1848(g)(3)(A) (42 U.S.C. 1395w-4(g)(3)(A)) is amended by inserting before the period at the end the following: "and the provisions of section 1902 (n)(3)(A) apply to further limit permissible charges under this section".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act.

* * * *

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2015) to provide for reconcilation pursuant to sections 104 to 105 of the concurrent resolution on the budget for fiscal year 1997, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

* * * *

MEDICAID PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING

Section 5712 of Senate amendment

CURRENT LAW

State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare, (dual eligibles) and for qualified Medicare beneficiaries (QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards.) The amount of required payment has been the subject of some controversy.

State Medicaid programs frequently have lower payment rates for services than the rates that would be paid under Medicare. Program guidelines permit states to pay either (1) the full Medicare deductible and coinsurance amounts or (2) cost-sharing charges only to the extent that the Medicare provider has not received the full Medicaid rate for an item or service. Some courts have forced state Medicaid programs to reimburse Medicare providers to the full Medicare allowable rates for services provided to QMBs and dually eligible individuals.

HOUSE BILL

No provision.

SENATE AMENDMENT

Clarifies that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB. Specifies that the Medicare payment plus the state's Medicaid payment will be considered payment in full and the QMB will not be liable for payment to a provider or managed care entity. Additionally, provides that any sanctions for excess charges that may be imposed on a provider

or managed care entity under Medicare may be imposed for making excess charges under Medicaid.

Applies to items and services furnished on or after the date of enactment. In the case of payment that is subject to a law suit pending as of the date of enactment, or initiated after the date of enactment, applies to items and services furnished before the date of enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

[LOGO]

June E. O'Neill
Director

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
Washington, D.C. 20515

August 12, 1997

Honorable Franklin D. Raines
Director
Office of Management and Budget
Washington, D.C. 20503

Dear Mr. Raines:

The Congressional Budget Office, after consulting with the Committees on the Budget of the House of Representatives and the Senate, provides the enclosed estimates of the effects of H.R. 2014 (Public Law 105-34), the Taxpayer Relief Act of 1997, and H.R. 2015 (Public Law 105-33), the Balanced Budget Act of 1997, on direct spending and receipts. These estimates are required by section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. H.R. 2014 and H.R. 2015 were cleared by the Congress on July 31 and signed by the President on August 5. Section 10213 of H.R. 2015 provides that these two laws are not counted for pay-as-you-go purposes.

On August 11 the President identified one provision of Public Law 105-33 and two provisions of Public Law 105-34 for cancellation under the terms of the Line Item Veto Act. CBO's estimates do not reflect the effects of the proposed cancellations.

Sincerely,

/s/ June E. O'Neill
JUNE E. O'NEILL

Enclosures

cc: Honorable John R. Kasich
Chairman, House Committee on the Budget

Honorable John M. Spratt, Jr.
Ranking Minority Member, House Committee on the Budget

Honorable Pete V. Domenici
Chairman, Senate Committee on the Budget

Honorable Frank R. Lautenberg
Ranking Minority Member, Senate Committee on the Budget

Honorable Bill Archer
Chairman, House Committee on Ways and Means

Honorable Charles B. Rangel
Ranking Minority Member, House Committee on Ways and Means

Honorable William V. Roth, Jr.
Chairman, Senate Committee on Finance

Honorable Daniel Patrick Moynihan
Ranking Minority Member, Senate Committee on Finance

BUDGETARY IMPLICATIONS OF THE BALANCED BUDGET ACT OF 1997

SUMMARY AND INTRODUCTION

As part of a plan to balance the federal budget by 2002, the 105th Congress enacted and President Clinton signed two major pieces of legislation: the Taxpayer Relief Act of 1997 (H.R. 2014/Public Law 105-34) and the Balanced Budget Act of 1997 (H.R. 2015/Public Law 105-33). The Balanced Budget Act achieves $127 billion in net deficit reduction over the 1998-2002 period. Gross savings of $160 billion comprise:

- $112 billion from slowing the growth of the Medicare program;
- $21 billion from auctioning licenses to use portions of the electromagnetic spectrum;
- $7 billion from changes to Medicaid;
- $5 billion from increasing excise taxes on cigarettes and other tobacco products; and
- $15 billion from other spending reductions and tax increases.

These savings are partly offset by additional spending of $33 billion:

- $20 billion for children's health insurance initiatives and
- $13 billion to mitigate the effects of last year's welfare reform law.

The act also extends the limits on discretionary spending and the pay-as-you-go procedures for direct spending and receipts, but these provisions do not directly alter federal outlays or revenues. The summary table provides estimates of the act's budgetary effects by title. The following pages give details by program and provision.

Table 4D.—Estimated Budgetary Impact of Subtitle H, Medicaid

(By fiscal year, in billions of dollars)	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2002 Total	1998-2007 Total
Medicaid rates for Medicare cost sharing for QMB and dually eligible beneficiaries												
Medicaid	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-1.7	-1.8	-5.0	-12.6
Medicare Benefits	0.5	0.5	0.6	0.6	0.7	0.7	0.8	0.9	1.0	1.0	2.9	7.3

SOURCE: Congressional Budget Office

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Medicaid Rates as Payment in Full. In recent years, many states have been required by court decisions to pay full Medicare rates for cost sharing for QMBs and people dually eligible for Medicare and Medicaid. This provision overturns these decisions and gives states the option not to pay providers Medicare cost sharing amounts in excess of Medicaid rates. According to the Physician Payment Review Commission, Medicaid payment rates are on average about 73 percent of Medicare payment rates. Limiting payment rates to providers for QMBs and dual eligibles to the lower payment rates will generate about $5 billion in federal Medicaid savings. However, CBO assumes that about one-third of the combined federal and state savings will be offset by behavioral responses by providers in the Medicare program, increasing Medicare costs by about $2.9 billion. The net federal savings in the two programs will be about $2.1 billion.

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MEDICARE HANDBOOK

1997

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HEALTH CARE FINANCING ADMINISTRATION

MEDICARE PART B COVERAGE

Medicare Part B pays for a wide range of medical services and supplies, but perhaps most important, it helps pay doctor bills.

The medically necessary services of a doctor are covered no matter where you receive them, whether at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital.

Benefit Limits

Some Part B benefits have special requirements, and some are more strictly limited than others. Pap smears, for example, are generally covered only every 3 years, mammograms every 24 months, and therapeutic shoes once a year for people who have severe diabetic foot disease.

You can receive services from an independent, Medicare-approved physical or occupational therapist. But the maximum Medicare will pay for each type of therapy in 1997 is $720.

Durable Medical Equipment: Wheelchairs and other durable medical equipment are covered only when prescribed by a doctor for use at home and when provided by a supplier approved by Medicare. You can find out what equipment is covered, and whether a supplier is approved, by calling Medicare's durable medical equipment (DME) regional carrier for your area. A state-by-state listing of DME carriers begins on page 29.

Ambulance Services: The ambulance benefit is also strictly limited. Medicare will help pay for the service only if:

1. The ambulance, equipment, and personnel meet Medicare requirements, *and;*
2. Transportation in any other vehicle could endanger your health.

Coverage is generally restricted to transportation between your home and a hospital, your home and a skilled nursing facility, or a hospital and a skilled nursing facility.

What's Not Covered: Many medical services and items are not covered by Medicare. They include, but are not limited to, routine physicals, most dental care, dentures, routine foot care, hearing aids, and most prescription drugs. Eyeglasses are covered only if you need corrective lenses after a cataract operation.

What You Pay

When you use your Part B benefits, you are responsible for paying the first $100 of the charges approved by Medicare. This is called the Part B annual deductible.

After the deductible is met, Medicare pays 80 percent of the Medicare-approved amount for most services. You are resonsible for the remaining 20 percent. This is called Part B coinsurance.

Sometimes your share of the bill is more than 20 percent of the Medicare-approved amount. If you receive outpatient services at a hospital, you are responsible for paying 20 percent of whatever the hospital charges, not 20 percent of a Medicare-approved amount. For some outpatient mental health services, your share is 50 percent of the Medicare-approved amount.

Besides having to pay Medicare's deductibles and coinsurance, you are responsible for all charges for services and supplies you receive that are not covered by Medicare.

What Is Assignment?

Always ask your doctors and medical suppliers whether they accept assignment. If they do, they will accept the amount Medicare approves for a particular service or supply and will not charge you more than the deductible and 20 percent coinsurance. That can mean savings for you.

Here's how. Let's suppose you go to a doctor who accepts assignment and that you have already paid the $100 Part B deductible for the year. Let's also assume that the Medicare-approved amount for the service you receive is $100.

Medicare would pay 80 percent of the $100 approved amount, or $80. You would be responsible for the other 20 percent, or $20. Medicare would pay its share of the bill directly to the doctor after the doctor filed your claim. The doctor could ask you to pay the $20 immediately but could not ask for more.

Here's what could happen if the doctor did not accept assignment. The doctor could charge $115, which is the $100 Medicare-approved amount plus the extra 15 percent that doctors who do not accept assignment are permitted to charge.

Medicare would pay 80 percent of $100, or $80 and you would be responsible for the remaining $35. But for doctors who do not accept Medicare assignment, Medicare will pay only its share of the bill, and the doctor could ask you to pay the $115 immediately. Medicare would send you a check for $80 after the doctor filed your claim.

Limiting Charge: Be aware that federal law prohibits a doctor who does not accept assignment from charging more than 15 percent above Medicare's approved amount. Any overcharges must be refunded. The following states offer stricter guidelines on limiting charges: Connecticut, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island, and Vermont. If you live in one of these states, check with your state's insurance counseling program for details. You will find the phone number in the resource directory at the back of this book.

Other Charge Limits: Doctors who do not accept assignment for elective surgery are required to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If you are not given a written esti-

mate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount for the surgery performed.

Additionally, any doctor who does not participate in Medicare and who provides you with a service that he or she knows or has reason to believe Medicare will determine to be medically unnecessary must tell you that in writing before performing the service. This is because Medicare will not pay for services it judges to be medically unnecessary. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

Participating Doctors and Suppliers: To avoid excess charges, go to doctors and medical suppliers who accept assignment. Some do on a case-by-case basis. Others sign agreements to accept assignment of all Medicare claims. They are called participating doctors and suppliers. You can get the names, addresses, and telehone numbers of participating doctors and suppliers by calling your Medicare carrier. You will find the phone number for your state's carrier in the resource directory of this book.

Part B Claims

Carriers are private insurance companies that contract with the federal government to process Medicare claims and make payments for services and supplies covered by Part B.

Every time you go to the doctor for a service covered by Medicare, the doctor is required by law to send the claim for payment to the carrier for the area where the service was provided. After processing your claim, the carrier usually will send you a notice about your benefits. It shows what was billed, the amount Medicare approved, and what you owe. It also tells you how to file an appeal if you disagree with a payment decision. Contact the

carrier with any questions about a Part B claim. The carrier's name and telephone number are printed on the benefit notice. A state-by-state listing of Medicare carriers begins on page 29.

If you get Medicare under the Railroad Retirement system, your claims are processed by the United Health Care office that serves your region. You can get the telephone number from any Railroad Retirement Board office.

Getting A Second Opinion

Sometimes your doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But, there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, you may want to get the opinion of another doctor before making a decision.

Medicare pays the same way for a second opinion as it pays for other doctor services as long as you are seeking advice for the treatment of a medical condition covered by Medicare. If the first two opinions contradict each other, Medicare will help pay for a third opinion. You can ask your own doctor to refer you to another doctor for a second opinion. Or, you can call your Medicare carrier and ask for the names and phone numbers of doctors in your area who provide second opinions.

PROGRAMS THAT HELP LOW-INCOME BENEFICIARIES

If you are a Medicare beneficiary with a very low income and few assets, you might qualify for state assistance in paying your health care costs. There are two programs that can help. One is called the "Qualified Medicare Beneficiary" (QMB) program and the other is called the "Specified Low-Income Medicare Beneficiary" (SLMB) program.

The QMB program pays Medicare's premiums, deductibles, and coinsurance for entitled older and disabled people who are qualified for Medicare Part A. If you do not have Part A or do not know if you are entitled, check with your local Social Security office, or call 1-800-772-1213. The TTY/TDD number for the hearing and speech impaired is 1-800-325-0778.

To be entitled to QMB, your income must be at or below the national poverty level and your financial resources (bank accounts, stocks, bonds, etc.) cannot be more than $4,000 for one person, or $6,000 for a couple. Some property, including the home you live in, one car, burial plots, and life insurance are usually not counted as resources.

The QMB monthly income limits for 1997 in the United States, for all States except Alaska and Hawaii, are:

- $678 for an individual
- $905 for a couple.

For Alaska, the QMB limits are $843 for an individual and $1126 for a couple.

For Hawaii, the QMB limits are $776 for an individual and $1037 for a couple.

MEDICARE PARTICIPATING PHYSICIANS OR SUPPLIER AGREEMENT [EXCERPT]

Name(s) and Address of Participant *
(Please Type or Print)

Physician or Supplier
Identification code(s) *

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. Meaning of Assignment—For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

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* List all names and identification codes under which the participant files claims with the carrier with whom this agreement is being filed.